

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 007377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/03/2014
NAME OF PROVIDER OR SUPPLIER INCARE HOME HEALTHCARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	<p>Initial Comments</p> <p>This was a revisit for the state complaint survey completed on March 11 - 18, 2014.</p> <p>Complaint #s IN00145226 and IN00145297 - Substantiated: State deficiencies related to the allegation are cited. Unrelated deficiencies are also cited</p> <p>Survey Date: May 28 - June 3, 2014</p> <p>Facility #: 007377</p> <p>Medicaid #: 200873250</p> <p>Surveyor: Ingrid Miller, MS, BSN, RN Public Health Nurse Surveyor</p> <p>During this survey, 11 deficiencies were found corrected. Fourteen deficiencies were recited. Eleven new deficiencies were cited.</p> <p>Active patients on census: 72 patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 13, 2014</p>	{N 000}		
{N 440}	<p>410 IAC 17-12-1(a) Home health agency administration/management</p> <p>Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable.</p> <p>This RULE is not met as evidenced by: Based on agency and Indiana State Department of Health (ISDH) document review and interview,</p>	{N 440}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{N 440}	Continued From page 1 the agency failed to ensure the organizational chart was accurate with the potential to affect all the agency's patients. Findings 1. The agency's organizational chart, dated 4/1/14, evidenced the agency had a contracted Social Worker (MSW). 2. The ISDH communication log with the agency stated, "5/11/12--Received notification that agency no longer offering MSW services, eff. 5.2.12. To HP/OMPP/CMS" This communication had been from the agency to the ISDH. 3. On 6/2/14 at 11:05 AM, Employee A, the administrator / director of nursing, indicated social work was not part of the agency services. However, the agency did have contracted MSW services and had not updated the state.	{N 440}		
N 444	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. This RULE is not met as evidenced by: Based on clinical record review, agency	N 444		

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N 444	<p>Continued From page 2</p> <p>document and policy review, other document review, and interview, the administrator failed to be knowledgeable about the agency's patients to organize and direct the agency's functions for 7 of 12 records (record #14 - #18, #21, #22) reviewed creating the potential to affect all of the agency's 72 current patients.</p> <p>The findings include</p> <p>Regarding clinical record #14</p> <p>1. Clinical record #14 evidenced skilled nursing services had been provided 1 - 2 times a week for 9 weeks during the certification period of 12/10/13 - 2/7/14 and also were provided on 2/18/14 and 3/7/14. The patient had been transferred to the hospital on 2/21/14 and returned home on 2/23/14. Neither a transfer or discharge had occurred to show that the patient had been discharged and then no resumption of care had occurred when the patient returned home. However, an oasis start of care assessment was completed by the RN on 2/26/14. The record was kept as a closed record in a file cabinet for closed records, but failed to evidence any discharge assessment or summary had been completed or that a resumption of care had been completed. It was not known that the patient had been discharged.</p> <p>a. A document titled "Community Healthcare System" dated 2/21/14 evidenced the patient had been hospitalized from 2/21/14 - 2/23/14 for a failing permacath.</p> <p>b. On 5/28/14 at 7 PM, patient #14 indicated that services stopped and that he / she had not been notified of this change in the plan of care.</p>	N 444		

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N 444	<p>Continued From page 3</p> <p>c. On 5/30/14 at 9:10 AM, Employee C indicated no hospital transfer or discharge oasis had been completed at patient #14's end of care. This was not following policy. Employee C indicated the patient had signed the patient rights and had signed consent for a new start of care on 2/26/14 and had been visited by the skilled nurse. There were no orders and no plan of care for this care provided.</p> <p>d. On 5/30/14 at 2:26 PM, Employee C indicated the patient had been discharged from the agency and there was no discharge assessment or discharge summary. The patient had been transferred to the hospital on 2/21/13 and returned home on 2/23/14. There was no resumption of care.</p> <p>Regarding clinical record #15</p> <p>2. Clinical record #15, start of care (SOC) 8/23/13 and a diagnosis of diabetes mellitus, included plans of care for the certification periods of 2/19/14 - 4/19/14 and 4/20/14 - 6/18/14. The plan of care for 2/19/14 - 4/19/14 was signed on 5/19/14 by the physician. This record evidenced the home health aide was to visit two times a week for 9 weeks for these certification period. The home health aide had been visiting the patient but had not turned in documentation since December 2013. The administrator was aware but the concern was not corrected or documented.</p> <p>a. On 5/29/14 at 12:05 PM, Employee A was called by phone with Employee C and Employee R present. Employee A indicated that Employee C was sent to patient #15's home to check if Employee S, home health aide (HHA), was still</p>	N 444		

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N 444	<p>Continued From page 4</p> <p>caring for this patient under the agency's care. Employee A indicated that Employee S had terminated earlier this year, but did not give a date of termination. Employee A stated, "Why she never reported this, I don't know. There is a physician order, but she maintains contact with the patient. This is under investigation with our consultant." Employee A indicated that Employee I, registered nurse (RN), is responsible for this. Employee A indicated that Employee I has made progress in her work with the agency but still needs to make improvement with documentation with her care of the patients. Employee A indicated that Employee I does supervise the home health aides well and was in charge of supervision of this aide. The patient was pleased with this care from the agency.</p> <p>b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15.</p> <p>c. On 5/29/14 at 4:50 PM, Employee C indicated visiting patient #15 over the past weekend. Patient #15 was happy with the services from Incare and the aide. Employee C indicated that she was sent in by Employee A to check on the services of an Employee S, HHA. Employee C indicated not knowing Employee S had resigned. She only knew that no documentation had been sent in for months from the Employee S HHA's visits and she was to investigate if Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services.</p> <p>d. On 5/30/14 at 11:55 AM, Employee S was called via telephone and spoke to writer and</p>	N 444		

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N 444	<p>Continued From page 5</p> <p>Employee C. She indicated still working for the agency and caring for patient #15. She indicated not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient that she saw for the agency. She indicated she was sorry she had not turned in the notes and asked if she was in trouble.</p> <p>e. A clinical document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance since 12/13." This included the signature of Employee A, administrator.</p> <p>f. Three clinical documents were evidenced to be home health aide care plans and were dated on 12/18/13, 2/18/14, and 4/18/14.</p> <p>Regarding clinical record #16</p> <p>3. Clinical record #16, SOC 10/23/13 and a diagnosis of bronchitis, included a plan of care for the certification period of 4/21/14 - 6/19/14 and was an active record. However, the patient had been transferred on 5/16/14 and then discharged. The patient was listed on the active patients list on 5/28/14. However, the clinical record was closed.</p> <p>a. A document titled "Incare Home Healthcare, inc. Patient Survey Census" with an effective date of 5/28/14 included patient #16's name, medicare #, date of birth, SOC date as 10/23/13 and certification period of 4/21/14 - 6/19/14, diagnosis of bronchitis, and disciplines of skilled nursing and home health aide.</p>	N 444		

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N 444	<p>Continued From page 6</p> <p>b. On 6/2/14 at 10:25 AM, Employee A indicated the discharge was pending in the computer software program called AXCESS, since she was still learning the features of the program.</p> <p>Regarding clinical record #17</p> <p>4. A document titled "Incare Home Healthcare, inc. Patient Survey Census" with an effective date of 5/28/14 included patient #17's name, medicare #, date of birth, SOC date as 2/2/14 and certification period of 4/3/14 - 6/1/14, diagnosis of benign hypertension, and disciplines of skilled nursing and home health aides.</p> <p>a. On 5/29/14 at 12:15 PM, Employee C, the alternate administrator, was unable to find patient #17's record.</p> <p>b. On 5/30/14 at 11:40 AM and at 1:10 PM, Employee C was unable to find patient #17's record.</p> <p>c. On 5/30/14 at 4 PM, the owner of the agency, Employee R, found the clinical record in the discharged records. The patient's last home health aide visit had occurred on 4/29/14 and the patient had been transferred to the hospital on that date. There was no transfer or discharge assessment evidenced in the clinical record.</p> <p>d. On 5/30/14 at 4:30 PM, Employee I, Registered Nurse, indicated the patient had been transferred to the hospital on 4/29/14 and was now discharged. No transfer or discharge assessment or summary had been completed.</p>	N 444		

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N 444	<p>Continued From page 7</p> <p>e. On 6/3/14 at 1:35 PM, Employee A, the administrator, indicated the patient was discharged and not active as indicated.</p> <p>Regarding Clinical record #18</p> <p>5. On 5/28/14 at 3:45 PM, Employee C indicated that patient #18's record was not able to be found. On 6/2/14 at 12:20 PM, Patient #18's record was located and had a discharge summary and assessment. The administrator indicated patient #18's record was complete.</p> <p>Regarding Clinical record #21 and #22</p> <p>6. Clinical record #21, SOC 10/4/13 and discharge on 3/25/14 and diagnosis of brain neoplasm, included a plan of care for the certification period of 2/1/14 - 4/1/14. The payment source was listed as Medicare. This plan of care indicated the patient was to receive skilled nurse visits 1 - 2 times weekly for 9 weeks and HHA visits for personal care including showers 1 - 2 times a week for 9 weeks. There were also HHA visits documented for 3/25/14, 4/3/14, 4/9/14, 4/11/14, 4/16/14, 4/18/14, 4/22/14, and 4/24/14 after the discharge of this patient. There was an aide care plan dated on 1/30/14 that had no tasks for the home health aide to complete.</p> <p>7. Clinical record #22, SOC 10/1/13 and a diagnosis of paraplegia, included a plan of care for the certification period of 3/30/14 - 5/28/14 and payment source as Medicare. Included in the record were HHA visits from record #21 with the name of patient #21 documented. Ordered on this plan of care was the skilled nurse frequency</p>	N 444		

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N 444	Continued From page 8 of 1 time a week for 9 weeks and HHA 2 times a week x 9 weeks. HHA visits occurred on 4/2/14, 4/4/14, 4/8/14, 4/10/14, 4/15/14, 4/17/14, 4/23/14, 4/25/14, 4/29/14, 4/30/14, 5/1/14, 5/7/14, 5/9/14, 5/13/14, and 5/15/14. Skilled nurse visits occurred on 3/25/14, 4/10/14, 4/23/14, 4/30/14, 5/7/14, 5/14/14, and 5/21/14. HHA visits for patient #21 were also in this record. These were from the following dates: 4/9/14, 4/11/14, 4/16/14, 4/18/14, 4/22/14, 4/24/14, 4/30/14, and 5/2/14. On 6/3/14 at 1:05 PM, the administrator indicated that she was looking into this situation with patients #21 and #22. She stated, "We are not benefiting from this. [The patient] has private pay." 8. The agency policy titled "Clinical documentation" with no effective date stated, "Agency will document each direct contact with the patient. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the patient's care ... to ensure that there is an accurate record of the services provided, patient response and ongoing need for care ... to document conformance with the plan of care, modifications to the plan, and interdisciplinary involvement ... documentation of the services ordered on the plan of care will be completed the day service is rendered and incorporated into the clinical record within 7 days after the care has been provided."	N 444			
{N 458}	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for	{N 458}			

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{N 458}	<p>Continued From page 9</p> <p>employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:</p> <ol style="list-style-type: none"> (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. <p>This RULE is not met as evidenced by: Based on personnel file and policy review and interview, the agency failed to ensure the personnel files contained annual evaluations, competency skills evaluation, and a criminal history as required in 4 of 7 employee files reviewed (S, U, X, Y) with the potential to affect all the patients of the agency.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Employee S, home health aide (HHA), date of hire 8/10/07 and unknown first patient contact, failed to evidence an annual evaluation had been completed since 2012. 2. Employee U, HHA, date of hire 4/9/09 and first patient contact in 2009, failed to include an annual evaluation since 2010 and a competency skills evaluation had been completed upon hire. 3. Employee X, Registered Nurse (RN), date of hire 3/28/14 and first patient contact 4/10/14, failed to include a criminal history. 	{N 458}		

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{N 458}	Continued From page 10 4. Employee Y, RN, date of hire 3/21/14 and first patient contact 4/10/14, evidenced a criminal history completed on 5/1/14. 5. The agency policy titled "Performance Evaluations" with no effective date stated, "A competency based performance evaluation will be conducted for all employees after 1 year of employment and at least annually thereafter." 6. The agency policy titled "Personnel Records" with no effective date stated, "Personnel files will be established and maintained for all personnel ... The personnel record for an employee will include ... criminal history and background checks as required by law." 7. On 5/29/14 at 12:21 PM, Employee C, RN, indicated the personnel records were not complete.	{N 458}		
{N 462}	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. This RULE is not met as evidenced by: Based on personnel file and policy review and interview, the agency failed to ensure all	{N 462}		

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{N 462}	Continued From page 11 employees had a physical examination no more than 180 days before first patient contact in 2 of 7 employee files reviewed (X and Y) with the potential to affect all the patients of the agency. Findings 1. Employee X, Registered Nurse (RN), date of hire 3/28/14 and first patient contact 4/10/14, failed to a completed physical examination. 2. Employee Y, RN, date of hire 3/21/14 and first patient contact 4/10/14, failed to evidence a physical examination had been completed. 3. On 5/29/14 at 12:21 PM, Employee C, RN, indicated the personnel records were not complete. 4. The agency policy titled "Health Screening" with no effective date stated, "Each employee having direct documentation of baseline health screening prior to providing care to patients ... Preemployment physical examination will be performed by a physician or nurse practitioner as mandated by state law or agency policy."	{N 462}		
{N 470}	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. This RULE is not met as evidenced by: Based on observation, interview, and review of procedures, the agency failed to ensure staff had provided services in accordance to professional	{N 470}		

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{N 470}	Continued From page 12 standards in 2 of 2 home visit observations (patient #19 and #20) completed creating the potential to affect any patients cared for by Employee I, registered nurse (RN), and Employee E, home health aide (HHA). The findings include 1. On 6/2/14 at 2:10 PM, Employee E, HHA, was observed to place her supply bag on patient #19's couch without a barrier. 2. On 6/2/14 at 3:45 PM, Employee I, RN was observed to place her nursing bag on patient #20's bed. After using her stethoscope and blood pressure cuff to assess patient #20, she replaced these supplies in the bag without disinfecting them. 3. The agency procedure titled "Competency Evaluation - Supply Bag Technique" with no effective date stated, "Bag placed on surface or hung from chair. Barrier utilized, if appropriate ... Equipment cleaned prior to returning to bag, as appropriate." 4. On 6/3/14 at 11:55 AM, the administrator indicated the visits above had not followed infection control standards.	{N 470}		
N 484	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be	N 484		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 484	<p>Continued From page 13</p> <p>documented in the clinical record or minutes of case conferences.</p> <p>This RULE is not met as evidenced by: Based on clinical record review, interview, and policy review, the agency failed to ensure all personnel furnishing services documented the coordination of care while services were being provided for 5 of 12 records reviewed (12, 15, 17, 21, and 22) with the potential to affect all agency patients receiving more than one service.</p> <p>Findings:</p> <p>1. Clinical record #12, start of care (SOC) 10/23/13 with a diagnosis of benign hypertension, included a plan of care for the certification period of 4/21/14 - 6/19/14 and services of home health aide services, skilled nurse, and podiatrist. The clinical record failed to show coordination of care between the skilled nurse, the home health aide, or the podiatrist.</p> <p>On 5/29/14 at 10:15 AM, Employee C indicated no coordination of care had occurred.</p> <p>2. Clinical record #15, SOC 8/23/13 and a diagnosis of diabetes mellitus, included plans of care for the certification periods of 2/19/14 - 4/19/14 and 4/20/14 - 6/18/14. The plan of care for 2/19/14 - 4/19/14 was signed on 5/19/14 by the physician. The services ordered were home health aide and skilled nurse services. This record evidenced the home health aide was to visit two times a week for 9 weeks for these certification periods. The home health aide had been visiting the patient but had not turned in documentation since December 2013. The administrator was aware but the concern was not corrected or documented. The record failed to</p>	N 484			

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N 484	<p>Continued From page 14</p> <p>evidence coordination between the skilled nurse and home health aide.</p> <p>a. On 5/29/14 at 12:05 PM, Employee A was called by phone with Employee C and Employee R present. Employee A indicated Employee C was sent to patient #15's home to check if Employee S, HHA, was still caring for this patient under the agency's care. Employee A indicated that Employee S had terminated earlier this year, but did not give a date of termination. Employee A stated, "Why she never reported this, I don't know. There is a physician order, but she maintains contact with the patient. This is under investigation with our consultant." Employee A indicated that Employee I, RN, is responsible for this. Employee A indicated that Employee I had made progress in her work with the agency but still needed to make improvement with documentation with her care of the patients. Employee A indicated that Employee I does supervise the home health aides well and was in charge of supervision of this aide. The patient was pleased with this care from the agency.</p> <p>b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15.</p> <p>c. On 5/29/14 at 4:50 PM, Employee C indicated visiting patient #15 over the past weekend. Patient #15 was happy with the services from Incare and the aide. Employee C indicated she was sent in by Employee A to check on the services of Employee S, HHA. Employee C indicated not knowing that the Employee S had resigned. She only knew that no documentation had been sent in for months from the Employee S HHA's visits and she was to investigate if</p>	N 484		

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N 484	<p>Continued From page 15</p> <p>Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services.</p> <p>d. On 5/30/14 at 11:55 AM, Employee S was called via telephone and spoke to writer and Employee C. She indicated still working for the agency and caring for patient #15. She indicated not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient she saw for the agency. She indicated she was sorry she had not turned in the notes and asked if she was in trouble.</p> <p>e. A document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance since 12/13." This included the signature of Employee A, administrator.</p> <p>f. Three documents were evidenced to be home health aide care plans and were dated on 12/18/13, 2/18/14, and 4/18/14.</p> <p>3. Clinical record #17, start of care 10/2/12 with a certification period of 4/3/14 - 6/1/14, included an order on the plan of care that stated, "Physician's order, 4/2/14, MSW [Master's of Social Work] eval [evaluation]" This was dated 4/2/14 and signed by Employee A, administrator and director of nursing, and not signed by the physician. The patient had a primary diagnosis of benign hypertension. The record failed to evidence coordination of care between the social worker or the nurse.</p>	N 484		

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N 484	<p>Continued From page 16</p> <p>a. On 5/30/14 at 4:45 PM, Employee C, the alternate administrator indicated the social work evaluation was not in the record and that no care coordination had occurred with the social worker or the nurse.</p> <p>b. On 6/3/14 at 1:30 PM, Employee A indicated the patient had refused to see a social worker. There was no order or other communication to the doctor or agency nurse about this care refusal and need for the patient to see the social worker.</p> <p>4. Clinical record #21, SOC 10/4/13 and discharge on 3/25/14 and diagnosis of brain neoplasm, included a plan of care for the certification period of 2/1/14 - 4/1/14. The payment source was listed as Medicare. This plan of care indicated the patient was to receive skilled nurse visits 1 - 2 X weekly for 9 weeks and HHA visits for personal care including showers 1 - 2 times a week for 9 weeks. There were also HHA visits documented for 3/25/14, 4/3/14, 4/9/14, 4/11/14, 4/16/14, 4/18/14, 4/22/14, and 4/24/14 after the discharge of this patient. There was an aide care plan dated on 1/30/14 that had no tasks for the home health aide to complete.</p> <p>On 6/3/14 at 7:45 AM, patient #21 indicated not knowing he / she was receiving services from the home health agency. Patient #21 indicated not being aware of being discharged. There was no care communication that showed the patient had been discharged in the record.</p> <p>5. Clinical record #22, SOC 10/1/13 and a diagnosis of paraplegia, included a plan of care for the certification period of 3/30/14 - 5/28/14 and payment source as Medicare. Included in the record were HHA visits from record #21 with the</p>	N 484		

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N 484	<p>Continued From page 17</p> <p>name of patient #21 documented. Ordered on this plan of care was the skilled nurse frequency of 1 time week for 9 weeks and HHA 2 times a week for 9 weeks. HHA visits occurred on 4/2/14, 4/4/14, 4/8/14, 4/10/14, 4/15/14, 4/17/14, 4/23/14, 4/25/14, 4/29/14, 4/30/14, 5/1/14, 5/7/14, 5/9/14, 5/13/14, and 5/15/14. SN visits occurred on 3/25/14, 4/10/14, 4/23/14, 4/30/14, 5/7/14, 5/14/14, and 5/21/14. HHA visits documented as to patient #21 were also in this record. These were from the following dates: 4/9/14, 4/11/14, 4/16/14, 4/18/14, 4/22/14, 4/24/14, 4/30/14, 5/2/14.</p> <p>a. On 6/3/14 at 10:25 AM, Employee W, registered nurse, indicated that patient #22 was the only one of patients #21 and #22 receiving home health aide services. Patient #21's visits were used for patient #22. Employee W indicated he was the primary nurse visiting patient #22 and conducting aide supervision. There was no documentation of care communication in the record between the services.</p> <p>b. On 6/3/14 at 1:05 PM, the administrator indicated that she was looking into this situation with patients #21 and #22. She stated, "We are not benefiting from this. [The patient] has private pay."</p> <p>6. The agency policy titled "Coordination of Patient services" with no effective date stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current Care plans and written and verbal interaction ... Interdisciplinary care conferences shall be conducted as often as necessary to</p>	N 484		

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N 484	Continued From page 18 respond to changes in the patient's needs, services, care, or goals ... Ongoing care conferences shall be conducted to evaluate the patient's status and progress." 7. The agency policy titled "Skilled Nursing Services" with no effective date stated, "The registered nurse a. Performs the initial assessment visit, b. Regularly reevaluates the patient needs, and coordinates necessary services."	N 484		
N 486	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. This RULE is not met as evidenced by: Based on clinical record review, interview, and policy review, the agency failed to ensure coordination of care occurred with other providers for 2 of 2 records reviewed of patients receiving services from another provider (14 and 16) with the potential to affect all agency patients receiving more than one service. Findings: 1. Clinical record #14, SOC 8/12/13 with a diagnosis of wound disruption, evidenced the patient was receiving dialysis services along with skilled nurse services. The clinical record failed to evidence coordination of care with the dialysis facility and the skilled nurse. a. On 5/28/14 at 7 PM, patient #14 indicated being on home hemodialysis at SOC and	N 486		

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N 486	<p>Continued From page 19</p> <p>completing this dialysis at home three times a week until switching to nocturnal hemodialysis in a nearby dialysis facility in December 2013. Patient #14 indicated telling the skilled nurse about this care received from a dialysis facility.</p> <p>b. On 5/30/14 at 9:45 AM, Employee C indicated there was no coordination of care noted in the record between the skilled nurse and dialysis facility.</p> <p>2. Clinical record #16, SOC 10/23/13 and diagnosis of bronchitis, failed to evidence coordination of care with an agency which provided homemaker services. Also an order for a social work evaluation on 4/21/14 evidenced the patient had refused. However, the order and refusal did not discuss any details about how the order was refused and if the social worker or physician were aware of the refusal. The record failed to evidence coordination of care with the other agency.</p> <p>a. On 6/2/14 at 10:30 AM, Employee CC, licensed practical nurse, indicated the patient was also seen by a home health agency that provided homemaker services.</p> <p>b. On 6/2/14 at 11:05 AM, the administrator indicated the patient had refused social work services and there was no other documentation about this refusal.</p> <p>3. The agency policy titled "Coordination of Patient services" with no effective date stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete,</p>	N 486			

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N 486	Continued From page 20 current Care plans and written and verbal interaction ... Interdisciplinary care conferences shall be conducted as often as necessary to respond to changes in the patient's needs, services, care, or goals ... Ongoing care conferences shall be conducted to evaluate the patient's status and progress." 4. The agency policy titled "Skilled Nursing Services" with no effective date stated, "The registered nurse a. Performs the initial assessment visit, b. Regularly reevaluates the patient needs, and coordinates necessary services."	N 486		
{N 494}	410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section. This RULE is not met as evidenced by: Based on interviews and review of policy, clinical records, and agency documents, the agency failed to ensure the patient's right to dignity was maintained for 3 of 12 records reviewed (patient #20, #21, #22) with the potential to affect all 72 patients of the agency.	{N 494}		

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{N 494}	<p>Continued From page 21</p> <p>Findings</p> <ol style="list-style-type: none"> 1. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the ... patient has the right to be informed about the care to be furnished, and of any changes in the care to be furnished as follows ... the patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity." 2. The agency admission package contained an undated document titled "Patient Bill of Rights and Responsibilities." 3. On 6/2/14 at 3:45 PM, patient #20 indicated having a complaint with a home health aide (HHA). The HHA had given him / her a choice of bath or having the bed made and not a choice of having both tasks done. The HHA, Employee D, had only visited twice. The patient had complained to the office about the care and asked to not have the aide return. This complaint had not been documented in the complaint log. <p>A review of clinical record #20 evidenced the patient had signed the patient rights at the start of care on 4/5/14.</p> <ol style="list-style-type: none"> 4. On 6/3/14 at 7:45 AM, patient #21 indicated not knowing that the he / she was receiving services from the home health agency. <p>A review of clinical record #21 indicated that the patient had signed the patient rights on 10/3/13.</p>	{N 494}			

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{N 494}	Continued From page 22 5. On 6/3/14 at 10:20 AM, patient #22's caregiver indicated Employee T, HHA, had stated, "If you want [patient #22] to get a shower, you will have to put [patient #22] in there yourself and then I will shower [the patient] when I arrive." A review of clinical record #22 indicated that the patient had signed the patient rights on 10/1/13. 6. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the ... patient has the right to be informed about the care to be furnished, and of any changes in the care to be furnished as follows ... the patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."	{N 494}			
N 504	410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. This RULE is not met as evidenced by: Based on policy review, agency document review, interview, and clinical record review, the agency	N 504			

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N 504	<p>Continued From page 23</p> <p>failed to ensure the patient was informed in advance of any changes in the care to be furnished in 3 of 12 records reviewed (#14, #21, #22) with the potential to affect all the agency's patients.</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The home health agency must protect and promote the exercise of these rights as follows ... the patient has the right to exercise his or her rights as a patient of the home health agency as follows ... the patient has the right to be informed about the care to be furnished and of changes in the care to be furnished ... the home health agency shall advise the patient in advance of disciplines that will furnish care, and the frequency of visits proposed to be furnished ... the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice." 2. The agency admission package contained a n undated document titled "Patient Bill of Rights and Responsibilities." 3. Clinical record #14, start of care 8/12/13, evidenced the patient had received the patient rights at the start of care and was not aware of the discharge of services that occurred in March 2014. <ul style="list-style-type: none"> a. On 5/28/14 at 7 PM, patient #14 indicated that nursing services were stopped without any notice in early March 2014. Patient #14 indicated filing a complaint with the office personnel and requested that Employee A, the administrator and director of nursing, investigate the complaint. 	N 504			

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N 504	<p>Continued From page 24</p> <p>This never occurred despite patient #14's numerous phone calls to the office and being told that the person that the patient needed to speak to was Employee A. At one call, the office staff put the call on speaker phone and patient #14 could hear Employee A talking about not having time to call patient #14 and complaining that the patient called several times. Employee A indicated on the speaker phone her intentions to call when the meeting occurring was done and at that time she would return call, but she never did return a call and never did investigate or resolve the patient's complaint. Patient #14 indicated needing supplies for an abdominal fistula dressing and did not receive any more of these supplies when the agency staff stopped visits without notice or discussing this failure to visit with her / him. Patient #14 indicated being on home hemodialysis at the start of care with the agency.</p> <p>b. On 5/29/14 at 10:25 AM, Employee C, Registered Nurse (RN), indicated the patient was not informed of the discharge.</p> <p>4. On 6/3/14 at 7:45 AM, patient #21 indicated not knowing he / she was receiving services from the home health agency. Patient #21 indicated not being aware of being discharged.</p> <p>a. A review of clinical record #21 indicated that the patient had signed the patient rights on 10/3/13.</p> <p>b. On 6/3/14 at 10:25 AM, Employee W, RN, indicated that patient #21 was not receiving the baths because instead patient #22 received these baths. This was done for convenience, he indicated.</p>	N 504		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 007377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/03/2014
NAME OF PROVIDER OR SUPPLIER INCARE HOME HEALTHCARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 504	Continued From page 25 5. On 6/3/14 at 10:25 AM, Employee W, RN, indicated that patient #22 was the only one of patients #21 and #22 receiving home health aide services. Patient #21's visits were used for patient #22. Employee W indicated he was the primary nurse visiting patient #22 and conducting aide supervision. A review of patient #22's file showed the patient had signed the rights at the start of care on 10/1/13. 6. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The home health agency must protect and promote the exercise of these rights as follows ... the patient has the right to exercise his or her rights as a patient of the home health agency as follows ... the patient has the right to be informed about the care to be furnished and of changes in the care to be furnished ... the home health agency shall advise the patient in advance of disciplines that will furnish care, and the frequency of visits proposed to be furnished ... the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice."	N 504		
N 505	410 IAC 17-12-3(b)(2)(D)(ii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency	N 505		

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N 505	<p>Continued From page 26</p> <p>shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment.</p> <p>This RULE is not met as evidenced by: Based on policy review, agency document review, interview, and clinical record review, the agency failed to ensure the patient was informed and participated of any changes in the care to be furnished in 3 of 12 records reviewed (#14, #21, #22) with the potential to affect all the agency's patients.</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The home health agency must protect and promote the exercise of these rights as follows ... the patient has the right to exercise his or her rights as a patient of the home health agency as follows ... the patient has the right to be informed about the care to be furnished and of changes in the care to be furnished ... the home health agency shall advise the patient in advance of disciplines that will furnish care, and the frequency of visits proposed to be furnished ... the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice." 2. The agency admission package contained a document titled "Patient Bill of Rights and Responsibilities." 3. Clinical record #14, start of care 8/12/13, evidenced the patient had received the patient rights at the start of care and was not aware of 	N 505			

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N 505	<p>Continued From page 27</p> <p>the discharge of services that occurred in March 2014.</p> <p>a. On 5/28/14 at 7 PM, patient #14 indicated that nursing services were stopped without any notice in early March 2014. Patient #14 indicated filing a complaint with the office personnel and requested that Employee A, the administrator and director of nursing investigate the complaint. This never occurred despite patient #14's numerous phone calls to the office and being told that the person that the patient needed to speak to was Employee A. At one call, the office staff put the call on speaker phone and patient #14 could hear Employee A talking about not having time to call patient #14 and complaining that the patient called several times. Employee A indicated on the speaker phone her intentions to call when the meeting occurring was done and at that time she would return call, but she never did return a call and ever did investigate or resolve the patient's complaint. Patient #14 indicated needing supplies for an abdominal fistula dressing and did not receive any more of these supplies when the agency staff stopped visits without notice or discussing this failure to visit with her / him. Patient #14 indicated being on home hemodialysis at the start of care with the agency.</p> <p>b. On 5/29/14 at 10:25 AM, Employee C, RN, indicated the patient was not informed of the discharge.</p> <p>4. On 6/3/14 at 7:45 AM, patient #21 indicated not knowing he / she was receiving services from the home health agency. Patient #21 indicated not being aware of being discharged.</p> <p>a. A review of clinical record #21 indicated that the patient had signed the patient rights on</p>	N 505		

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N 505	Continued From page 28 10/3/13. b. On 6/3/14 at 10:25 AM, Employee W, RN, indicated that patient #21 was not receiving the baths because instead patient #22 received these baths. This was done for convenience, he indicated. 5. On 6/3/14 at 10:25 AM, Employee W, RN, indicated that patient #22 was the only one of patients #21 and #22 receiving home health aide services. Patient #21's visits were used for patient #22. Employee W indicated he was the primary nurse visiting patient #22 and conducting aide supervision. A review of the patient #22's file showed the patient had signed the rights at the start of care on 10/1/13. 6. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The home health agency must protect and promote the exercise of these rights as follows ... the patient has the right to exercise his or her rights as a patient of the home health agency as follows ... the patient has the right to be informed about the care to be furnished and of changes in the care to be furnished ... the home health agency shall advise the patient in advance of disciplines that will furnish care, and the frequency of visits proposed to be furnished ... the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice."	N 505			
N 506	410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights Rule 12 (b) The patient has the right to exercise	N 506			

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NAME OF PROVIDER OR SUPPLIER INCARE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		
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N 506	<p>Continued From page 29</p> <p>his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice.</p> <p>This RULE is not met as evidenced by: Based on policy review, agency document review, interview, and clinical record review, the agency failed to ensure the patient was informed in advance of any changes in the care to be furnished in 3 of 12 records reviewed (#14, #21, #22) with the potential to affect all the agency's patients.</p> <p>Findings include</p> <p>1. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The home health agency must protect and promote the exercise of these rights as follows ... the patient has the right to exercise his or her rights as a patient of the home health agency as follows ... the patient has the right to be informed about the care to be furnished and of changes in the care to be furnished ... the home health agency shall advise the patient in advance of disciplines that will furnish care, and the frequency of visits proposed to be furnished ... the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice."</p> <p>2. The agency admission package contained a n undated document titled "Patient Bill of Rights</p>	N 506			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 007377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 06/03/2014
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N 506	<p>Continued From page 30</p> <p>and Responsibilities."</p> <p>3. Clinical record #14, start of care 8/12/13, evidenced the patient had received the patient rights at the start of care and was not aware of the discharge of services that occurred in March 2014.</p> <p>a. On 5/28/14 at 7 PM, patient #14 indicated that nursing services were stopped without any notice in early March 2014. Patient #14 indicated filing a complaint with the office personnel and requested that Employee A, the administrator and director of nursing, investigate the complaint. This never occurred despite patient #14's numerous phone calls to the office and being told that the person that the patient needed to speak to was Employee A. At one call, the office staff put the call on speaker phone and patient #14 could hear Employee A talking about not having time to call patient #14 and complaining that the patient called several times. Employee A indicated on the speaker phone her intentions to call when the meeting occurring was done and at that time she would return call, but she never did return a call and never did investigate or resolve the patient's complaint. Patient #14 indicated needing supplies for an abdominal fistula dressing and did not receive any more of these supplies when the agency staff stopped visits without notice or discussing this failure to visit with her / him. Patient #14 indicated being on home hemodialysis at the start of care with the agency.</p> <p>b. On 5/29/14 at 10:25 AM, Employee C, Registered Nurse (RN), indicated the patient was not informed of the discharge.</p> <p>4. On 6/3/14 at 7:45 AM, patient #21 indicated</p>	N 506			

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N 506	<p>Continued From page 31</p> <p>not knowing he / she was receiving services from the home health agency. Patient #21 indicated not being aware of being discharged.</p> <p>a. A review of clinical record #21 indicated that the patient had signed the patient rights on 10/3/13.</p> <p>b. On 6/3/14 at 10:25 AM, Employee W, RN, indicated that patient #21 was not receiving the baths because instead patient #22 received these baths. This was done for convenience, he indicated.</p> <p>5. On 6/3/14 at 10:25 AM, Employee W, RN, indicated that patient #22 was the only one of patients #21 and #22 receiving home health aide services. Patient #21's visits were used for patient #22. Employee W indicated he was the primary nurse visiting patient #22 and conducting aide supervision.</p> <p>A review of patient #22's file showed the patient had signed the rights at the start of care on 10/1/13.</p> <p>6. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The home health agency must protect and promote the exercise of these rights as follows ... the patient has the right to exercise his or her rights as a patient of the home health agency as follows ... the patient has the right to be informed about the care to be furnished and of changes in the care to be furnished ... the home health agency shall advise the patient in advance of disciplines that will furnish care, and the frequency of visits proposed to be furnished ... the home health agency shall advise the patient of any change in the plan of care, including</p>	N 506			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 007377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/03/2014
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N 506	Continued From page 32 reasonable discharge notice."	N 506		
N 508	410 IAC 17-12-3(b)(2)(E) Patient Rights Rule 12 Sec. 3(b)(2)(E) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (E) Confidentiality of the clinical records maintained by the home health agency. The home health agency shall advise the patient of the agency's policies and procedures regarding disclosure of clinical records. This RULE is not met as evidenced by: Based on policy review and text and document review and interview, the agency failed to ensure the patient's right to confidential clinical record information had been protected when employee I shared her password to access clinical information with another person for 1 of 1 agency creating the potential to affect all of the agency's 72 current patients. The findings include: 1. The agency policy titled "Patient Privacy Rights" with no effective date stated, "Patient privacy rights will be presented to all patients at the time of admission with the Home Care Bill of Rights ... to inform patients of the agency of their rights of privacy. To accommodate patient privacy rights as specified in the privacy rule of the Health Information and Accountability Act regulation." 2. These are text exchanges from the	N 508		

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N 508	Continued From page 33 complainant to Employee I, Registered Nurse. a. On 4/1/14 at 6:33 PM unknown person texted to Employee I, "Please call me. You have errors in your cert for [patient #7]" b. From Complainant to Employee I at 7:45 PM, "That's not the right password." c. From Employee I at 7:50 PM, [password given]. d. From complainant at 7:50 PM, " Thank you dear." e. On 4/2/14 at 12:14 PM, From complainant to Employee I , " Are going to be seeing [patient #17] today?" 3. On 5/30/14 at 3:15 PM, Employee I wrote her AXXESS password on an envelope. (This matched the texted password noted in the complaint documents.) 4. On 6/3/14 at 3:35 PM, Employee I indicated the text was from her phone. She indicated she would only share passwords with Employee A, the owner's wife, and Employee R.	N 508		
{N 514}	410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished.	{N 514}		

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{N 514}	<p>Continued From page 34</p> <p>(B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency.</p> <p>(2) Document both the existence of the complaint and the resolution of the complaint.</p> <p>This RULE is not met as evidenced by: Based on policy review, clinical record review, administrative document review, and interview, the agency failed to follow their own policy to investigate complaints and document the existence and resolution of the complaint for 5 of 12 records reviewed with the potential to affect all of the patients served by the agency. (#12, 14, 19, 20, and 22)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The patient has the right to exercise his or her rights as a patient of the home health agency as a patient of the home health agency as follows ... the patient has the right to place a complaint with the department regarding treatment or care furnished by a home health agency ... to voice complaints about care or treatment ... the organization investigates the complaint and resolution of the same." 2. The agency admission package contained an undated document titled "Patient Bill of Rights and Responsibilities." 3. Clinical record #12, start of care 10/23/13, evidenced the patient had received the patient rights at the start of care and failed to have a complaint documented, investigated, or resolved. The complaint log failed to evidence the complaint. 	{N 514}			

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{N 514}	<p>Continued From page 35</p> <p>On 4/23/14 at 4:23 PM, the patient indicated having a complaint that had not been addressed by the administrator. The patient had complained of not receiving aide visits as ordered on the plan of care.</p> <p>4. Clinical record #14, start of care 8/12/13, evidenced the patient had received the patient rights at the start of care and failed to have a complaint documented, investigated, or resolved. The complaint log failed to evidence the complaint.</p> <p>a. On 5/28/14 at 7 PM, patient #14 indicated that nursing services were stopped without any notice. Patient #14 indicated filing a complaint with the office personnel and requested that Employee A, the administrator and director of nursing, investigate the complaint. This never occurred despite patient #14's numerous phone calls to the office and being told that the person that the patient needed to speak to was Employee A. At one call, the office staff put the call on speaker phone and patient #14 could hear Employee A talking about not having time to call patient #14 and complaining that the patient called several times. Employee A indicated on the speaker phone her intentions to call when the meeting occurring was done and at that time she would return call, but she never did return a call and never did investigate or resolve the patient's complaint. Patient #14 indicated needing supplies for an abdominal fistula dressing and did not receive any more of these supplies when the agency staff stopped visits without notice or discussing this failure to visit with her / him. Patient #14 indicated being on home hemodialysis at the start of care with the agency.</p>	{N 514}			

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{N 514}	<p>Continued From page 36</p> <p>b. On 5/29/14 at 10:25 AM, Employee C, Registered Nurse indicated the complaint had not been filed in the complaint log.</p> <p>5. Clinical record #19, start of care 4/5/2014, had received the patient rights at the start of care and had not had a complaint documented, investigated, or resolved. The complaint log failed to evidence the complaint</p> <p>On 6/2/14 at 2:10 PM, patient #19 complained that the physical therapist had called and canceled and had said that a visit would occur that weekend. No visit had occurred. The patient indicated calling the office and complaining and that no follow-up had occurred.</p> <p>6. On 6/2/14 at 3:45 PM, patient #20 indicated having a complaint with a home health aide (HHA). The HHA had given him / her a choice of bath or having the bed made and not a choice of having both tasks done. The HHA, Employee D, had only visited twice. The patient had complained to the office about the care and asked to not have the aide return. This complaint had not been documented in the complaint log.</p> <p>A review of clinical record #20 evidenced the patient had signed the patient rights at the start of care on 4/5/14.</p> <p>7. Clinical record #22, start of care 10/1/13, evidenced the patient had received the patient rights at the start of care and failed to have a complaint documented, investigated, or resolved. The complaint log failed to evidence the complaint.</p> <p>On 6/3/14 at 11 AM, the power of attorney for patient #22 and informal caregiver of patient #22</p>	{N 514}		

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{N 514}	Continued From page 37 indicated calling Employee A with a complaint that the patient was receiving sponge baths and not showers that had been agreed upon. He/she indicated receiving no follow up with his complaint. In February, the power of attorney had also complained and requested that any time the plan of care was altered or days were changed that he /she should be contacted. There was no follow up with this complaint. The power of attorney indicated last week to talk to the administrator about the patient not receiving showers as requested and getting no response. 8. A review of the complaint log failed to evidence any investigation or other documentation concerning the complaint filed by patient #12, #14, #19, #20, #22.	{N 514}		
{N 520}	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. This RULE is not met as evidenced by: Based on agency document review, clinical record review, policy review, and interview, the agency failed to ensure patients needs were addressed and being met adequately by the agency in the patient's place of residence in 6 of 12 patient records (12, 14, 16, 17, 19, 22) reviewed creating the potential to affect all patients of the agency. Findings include: 1. Clinical record #12, start of care (SOC)	{N 520}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 520}	<p>Continued From page 38</p> <p>10/23/13, included a plan of care for the certification period of 4/21/14 - 6/19/14 with orders for home health aide (HHA) 1 - 2 times a week for 9 weeks. However, no visits occurred until May 14, 2014.</p> <p>a. On 4/23/14 at 4:23 PM, the patient indicated having a complaint that had not been addressed by the administrator. The patient had complained of not receiving aide visits as ordered on the plan of care and not having his / her needs met.</p> <p>b. On 5/29/14 at 10:12 AM, Employee C, Registered Nurse (RN), indicated the plan of care had not been followed and HHA visits were missing from the clinical record.</p> <p>2. Clinical record #14, start of care 8/12/13, evidenced the patient had received the patient rights at the start of care and failed to have a complaint documented, investigated, or resolved and the patient was not told of a pending discharge or ceasing of services.</p> <p>a. On 5/28/14 at 7 PM, patient #14 indicated that nursing services were stopped without any notice in early March 2014. Patient #14 indicated filing a complaint with the office personnel and requested that Employee A, the administrator and director of nursing, investigate the complaint. This never occurred despite patient #14's numerous phone calls to the office and being told the person the patient needed to speak to was Employee A. At one call, the office staff put the call on speaker phone and patient #14 could hear Employee A talking about not having time to call patient #14 and complaining that the patient called several times. Employee A indicated on the speaker phone her intentions to call when the</p>	{N 520}		

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{N 520}	<p>Continued From page 39</p> <p>meeting occurring was done and at that time she would return call, but she never did return a call and ever did investigate or resolve the patient's complaint. Patient #14 indicated needing supplies for an abdominal fistula dressing and did not receive any more of these supplies when the agency staff stopped visits without notice or discussing this failure to visit with her / him. Patient #14 indicated being on home hemodialysis at the start of care with the agency.</p> <p>b. On 5/29/14 at 10:25 AM, Employee C, RN, indicated the patient's needs had not been met.</p> <p>3. Clinical record #16, start of care 10/23/13 and diagnosis of bronchitis, included a plan of care for the certification period of 4/21/14 - 6/19/14 which failed to evidence the patient's needs had been met. The patient had a Social Worker (MSW) Evaluation ordered on 4/21/14. The record failed to evidence that the physician was notified of the patient's refusal for the social work visit. No community resources were made available to the patient. No social work interventions occurred. The director of nursing was contacted and did not write any notes in this clinical record.</p> <p>a. On 4/10/14 at 6:52 PM, the home physician wrote the following clinical note: "Patient needs to have a more appropriate and safe living situation. Will order social services ... patient needs place in a skilled facility ... cannot move and lives alone."</p> <p>b. On 4/18/14 at 5:15 PM, the licensed practical nurse (LPN), Employee C, stated in a clinical note, "Will contact SS [Social Services regarding living conditions]." This did not occur.</p> <p>c. A clinical note written by Employee W,</p>	{N 520}		

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{N 520}	<p>Continued From page 40</p> <p>registered nurse (RN), on 5/13/14 at 11:35 AM under Care coordination to Employee A, director of nursing, "Patient needs evaluation by home MD for possible assisted living or nursing home placement. Need for MSW also relayed. Current frequency for SN [skilled nurse] and HHA needs to be increased. MD and DON [director of nursing] to see patient this PM."</p> <p>d. On 6/2/14 at 11:05 AM, the administrator indicated the patient had refused social work services and there was no documentation about this refusal or when this refusal occurred.</p> <p>e. On 5/16/14 at 11:30 AM, a clinical note written by Employee W, Registered Nurse, stated, "Pt [patient] assessment ... lethargic but arouseable ... 911 notified for ambulance transfer condition report given." Patient was transferred to hospital.</p> <p>4. Clinical record #17, SOC 10/2/12 with a certification period of 4/3/14 - 6/1/14 included an order on the plan of care that stated, "Physician's order, 4/2/14, MSW eval [evaluation]" This was dated 4/2/14 and signed by Employee A, administrator and director of nursing, and not signed by the physician.</p> <p>a. On 5/30/14 at 4 PM, Employee I, Registered Nurse, indicated the patient had fallen on 4/24/14 and then cut self on arms on 4/29/14 with a knife. Employee E, the home health aide, called with an update and employee I called the physician. Employee I did not write any notes on this incident and did not write a transfer oasis. An informal caregiver took the patient to the emergency room where the patient was admitted and stayed several days.</p>	{N 520}		

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{N 520}	<p>Continued From page 41</p> <p>b. On 5/30/14 at 4:45 PM, Employee C, the alternate administrator indicated the social work evaluation was not in the record.</p> <p>c. On 6/3/14 at 1:30 PM, Employee A indicated the patient had refused to see a social worker. There was no order or other communication to the doctor about this refusal.</p> <p>5. Clinical record #19, start of care 4/5/2014, had received the patient rights at the start of care and had not had a complaint documented, investigated, or resolved.</p> <p>On 6/2/14 at 2:10 PM, patient #19 complained that the physical therapist had called and canceled and had said that a visit would occur that weekend. No visit had occurred. The patient indicated calling the office and complaining and that no follow-up had occurred.</p> <p>6. Clinical record #22, start of care 10/1/13, evidenced the patient had received the patient rights at the start of care and failed to have a complaint documented, investigated, or resolved.</p> <p>On 6/3/14 at 11 AM, the power of attorney for patient #22 and informal caregiver of patient #22 indicated calling Employee A with a complaint that the patient was receiving sponge baths and not showers that had been agreed upon. He/she indicated receiving no follow up with his complaint. In February, the power of attorney had also complained and requested that any time the plan of care was altered or days were changed that he /she should be contacted. There was no follow up with this complaint. The power of attorney indicated last week to talk to the administrator about the patient not receiving showers as requested and getting no response.</p>	{N 520}			

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{N 520}	Continued From page 42 8. A review of the complaint log failed to evidence any investigation or other documentation concerning the complaint filed by patient #12, #14, #19, #20, #22. 9. The agency policy titled "Patient Admission Process" with no effective date stated, "If the agency cannot fulfill the required health need, a referral will be made to other appropriate community resources and referral source will be notified." 10. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "Be admitted only if we can provide the care you need." 11. The agency admission package contained a document titled "Patient Bill of Rights and Responsibilities."	{N 520}			
{N 522}	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure services and treatments had been provided in accordance with physician's orders in 8 of 12 records reviewed (#7, 12, 13, 14, 15, 16, 19, 20) creating the potential to affect all of the agency's 72 current patients.	{N 522}			

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{N 522}	<p>Continued From page 43</p> <p>Findings</p> <p>1. Clinical record #7, start of care (SOC) 7/26/13 with a diagnosis of Congestive Heart Failure, included a plan of care for the certification period of 3/23/14 - 5/21/14 with orders for occupational therapy (OT) visits. The orders failed to include frequency for the visits which occurred on 3/25/14, 3/27/14, 4/3/14, 4/8/14, and 4/10/14. Skilled nurse visits were also ordered on the plan of care. A nurse visit on 4/11/14 at 9 AM, failed to show that the nurse had completed the tasks ordered on the plan of care including assessing for edema and peripheral circulation. The nurse failed to complete a body system assessment that was ordered. The nurse failed to complete a pain assessment.</p> <p>On 5/20/14 at 2:55 PM, Employee C, Registered Nurse (RN) indicated the visits above did not follow the plan of care.</p> <p>2. Clinical record #12, SOC 10/23/13 with a diagnosis of benign hypertension, evidenced no plan of care for the certification period of 4/21/14 - 6/19/14 on 5/29/14 at 10:15 AM. On 6/2/14 at 10 AM, the clinical record did contain a plan of care for the certification period of 4/21/14 - 6/19/14. This plan of care evidenced the skilled nurse was to visit the patient 1 times a week for 9 weeks to assess pain level, instruction on shortness of breath, weekly weights, assess and instruct on pain management, proper body mechanics and safety measures, to instruct on proper foot wear when ambulating, and to encourage the patient to see a podiatrist. No skilled nurse visits were completed in the clinical record. The home health aide was to visit 1 - 2 times a week for assist with activities of daily</p>	{N 522}			

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{N 522}	<p>Continued From page 44</p> <p>living. The only aide visit notes in the record were on 5/14/14 and 5/16/14. No other aide notes were present for the current certification period.</p> <p>a. On 5/29/14 at 10:15 AM, Employee C indicated the plan of care had not been completed and was not part of the clinical record and skilled nurse visits and home health aide visits were not in the record.</p> <p>b. On 5/29/14 at 2:00 PM, Employee I, registered nurse (RN), was observed to have a piece of paper with visit notes for the past two months noted on this paper. She indicated she did not document the visit until later at home. This paper was divided into about 8 sections and vital signs and the date were recorded. The paper did not indicate what part of the plan of care had been completed besides vital signs. There was no pain assessments or instructions for proper foot wear noted.</p> <p>c. On 6/3/14 at 2 PM, Employee A indicated the skilled nurse visits were missing from the record and documentation of a visit should be on a visit note or in the software program for skilled nurse visits used by the agency. Employee A indicated Employee I had not been documenting her skilled nurse visits timely or according to policy.</p> <p>3. Clinical record #13, SOC 3/29/14, evidenced a plan of care for the certification period of 3/29/14 - 5/27/14 that was electronically signed by Employee I on 3/25/14. The physician signed this plan of care on 5/10/14. Skilled nurse visits were made on 4/15/14, 4/22/14, 4/29/14, 5/9/14, 5/17/14, 5/20/14, and 5/27/14. There was no frequency of skilled nurse visits on this plan of care.</p>	{N 522}			

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{N 522}	<p>Continued From page 45</p> <p>On 5/30/14 at 2:25 PM, Employee C indicated the skilled nurse had not followed the plan of care.</p> <p>4. Clinical record #14 with a diagnosis of wound disruption evidenced two starts of care. One occurred on 8/12/13 and the other on 2/26/14. The record evidenced a plan of care for the certification period of 12/10/13 - 2/7/14, which was signed on 1/16/14. There was no other plan of care after this certification period. There were no orders for skilled nurse visits which were documented on 2/18/14 and 3/7/14. An oasis start of care assessment was completed by the RN on 2/26/14.</p> <p>On 5/30/14 at 9:45 AM, Employee C indicated there were no orders on the plan of care for the skilled nurse visits that occurred on 2/18/14 and 3/7/14 and the oasis start of care assessment completed by the RN on 2/26/14.</p> <p>5. Clinical record #15, SOC 8/23/13 and a diagnosis of diabetes mellitus, included plans of care for the certification periods of 12-21-13 - 2-18-14 (HHA to visit 1 - 2 times a week and skilled nurse 1 - 2 times a week), 2/19/14 - 4/19/14 (HHA 2 times a week and skilled nurse (SN) 1 times a week) and 4/20/14 - 6/18/14 (SN one times a week). The plan of care for 2/19/14 - 4/19/14 was signed on 5/19/14 by the physician. The home health aide had been visiting the patient but had not turned in documentation since December 2013. The administrator was aware but the concern was not corrected or documented. Home health aide visits had been made since December 2013 with no documentation in the record. Therefore, it could not be determined if they were made as ordered</p>	{N 522}			

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{N 522}	<p>Continued From page 46</p> <p>or whether the correct tasks were performed. The patient had physical therapy and occupational therapy visits ordered on 4/20/14 and 5/8/14 and these visits did not occur. There was no documentation in the record why these visits did not occur.</p> <p>a. On 5/29/14 at 12:05 PM, Employee A was called by phone with Employee C and Employee R present. Employee A indicated that Employee C was sent to patient #15's home to check if Employee S, HHA, was still caring for this patient under the agency's care. Employee A indicated that Employee S had terminated earlier this year, but did not give a date of termination. Employee A stated, "Why she never reported this, I don't know. There is a physician order, but she maintains contact with the patient. This is under investigation with our consultant." Employee A indicated that Employee I, RN, is responsible for this. Employee A indicated that Employee I has made progress in her work with the agency but still needs to make improvement with documentation with her care of the patients. Employee A indicated that Employee I does supervise the home health aides well and was in charge of supervision of this aide. The patient was pleased with this care from the agency.</p> <p>b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15.</p> <p>c. On 5/29/14 at 4:50 PM, Employee C indicated visiting patient #15 over the past weekend. Patient #15 was happy with the services from Incare and the aide. Employee C indicated that she was sent in by Employee A to check on the services of an Employee S, HHA.</p>	{N 522}			

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{N 522}	<p>Continued From page 47</p> <p>Employee C indicated not knowing that the Employee S had resigned. She only knew that no documentation had been sent in for months from the Employee S HHA's visits and she was to investigate if Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services.</p> <p>d. On 5/30/14 at 11:55 AM, Employee S called via telephone and spoke to writer and Employee C. She indicated she was still working for the agency and caring for patient #15. She indicated not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient she saw for the agency. She indicated she was sorry she had not turned in the notes and asked if she was in trouble.</p> <p>e. On 5/30/14 at 1:10 PM, Employee C indicated the plan of care was not followed and the therapy visits never occurred.</p> <p>f. A clinical document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance since 12/13." This included the signature of Employee A, administrator.</p> <p>g. Three clinical documents in the record were home health aide care plans and were dated on 12/18/13, 2/18/14, and 4/18/14.</p> <p>6. Clinical record #16, start of care 10/23/13 and diagnosis of bronchitis, evidenced the skilled nurse used triple antibiotic ointment on the patient's skin tear on without obtaining an order</p>	{N 522}			

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{N 522}	<p>Continued From page 48</p> <p>on 5/13/14 at 11:35 AM. It was not documented where the skin tear was.</p> <p>On 6/2/14 at 11:20 AM, Employee A, the administrator, indicated there was no order for this treatment.</p> <p>7. Clinical record #19, SOC 4/17/14 and diagnosis of obstructive chronic bronchitis, included a plan of care for the certification period of 4/17/14 - 6/15/14. The record failed to evidence the patient had received the physical and occupational therapy visits ordered on 4/17/14.</p> <p>On 6/3/14 at 2 PM, Employee A indicated these visits did not occur.</p> <p>8. Clinical record #20, SOC 4/5/14 and a diagnosis of chronic airway obstructive, included a plan of care for the certification period of 4/5/14 - 6/3/14, evidenced orders for PT evaluation and treatment and OT evaluation and treatment. These visits had not occurred. A new order was written on 5/5/14 and an evaluation for PT occurred on 5/10/14. No OT visits occurred.</p> <p>On 6/3/14 at 2:45 PM, Employee A, the administrator, indicated they had been locked out of the therapy site and could not access patient records.</p> <p>9. The agency policy titled "Medical Supervision" with no effective date stated, "A physician plan of care is developed for each patient at the time of admission and signed by the physician in the appropriate time frame ... agency responsibilities include prompt reporting of a change in patient condition ... support of a physician plan of care."</p>	{N 522}		

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{N 522}	Continued From page 49 10. The agency policy titled "Scope of Practice" with no effective date stated, "Agency will provide services that are in compliance with acceptable professional standards for the Home Care Industry as well as the state and federal laws and identified agency performance improvement standards ... patient care will be provided under the plan of care established by a physician ... agency staff will deliver services based on each patient's unique and individual needs." 11. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. The plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... An individualized plan of care signed by the physician shall be required for each patient receiving home health and personal care services. The plan of care shall be completed in full to include ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for changes in the plan of care."	{N 522}		
{N 524}	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan	{N 524}		

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{N 524}	<p>Continued From page 50</p> <p>of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>This RULE is not met as evidenced by: Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care was signed by the physician timely and included all required elements for 8 of 12 records reviewed (#7, 12, 13, 14, 15, 16, 17, 19) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #7, start of care (SOC) 7/26/13 with a diagnosis of Congestive Heart Failure, included a plan of care for the certification period of 3/23/14 - 5/21/14 that was not signed by the</p>	{N 524}		

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{N 524}	<p>Continued From page 51</p> <p>physician. The plan of care for the certification period of 5/22/14 - 7/20/14 had not been completed on 5/30/14 at 3 PM. The plan of care included orders for occupational therapy, but they lacked frequency and duration of the visits. The medication list on the plan of care for these certification periods lacked the reason the medications were given for the as needed medications including polyethylene glycol and hydrocodone with Tylenol.</p> <p>a. On 5/30/14 at 2:55 PM, Employee C, Registered Nurse (RN), indicated the plan of care was not completed by the physician and the new plan of care for the certification period was not complete. The occupational therapy orders lacked frequency and duration of the visits.</p> <p>b. On 5/30/14 at 3 PM, Employee C indicated the plan of care for the most recent certification period was not completed timely.</p> <p>2. Clinical record #12, SOC 10/23/13 with a diagnosis of benign hypertension, evidenced that the physician had signed the plan of care for the certification period of 4/21/14 - 6/19/14 until 6/1/14. This plan of care failed to list the purpose of the as needed medications including hydrocodone / acetaminophen 10 - 325 mg (milligrams) every 6 - 8 hours as needed and ambien 5 mg oral tablet prn po (by mouth). Additionally, the ambien did not evidence how many tablets a day would be given and at what time of day the medication would be given.</p> <p>a. On 5/29/14 at 10:15 AM, Employee C indicated the plan of care had not been signed in a timely manner.</p> <p>b. On 5/30/14 at 2:55 PM, Employee C</p>	{N 524}		

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{N 524}	<p>Continued From page 52</p> <p>indicated the plan of care did not have the medications listed correctly.</p> <p>3. Clinical record #13, SOC 9/30/13 with a diagnosis of chronic pain, included a plan of care for the certification period of 3/29/14 - 5/27/14 and also for 5/28/14 - 7/26/14 which failed to evidence a complete medication list. Fentanyl patch was listed without the dose, frequency, or route of administration. The plan of care for 5/28/14 - 7/26/14 evidenced the skilled nurse was to assess the patient's pain level and effectiveness of pain medications and current pain management therapy at every visit. Skilled nurse was to instruct patient to take pain medication before becomes severe to achieve better pain control. There were no measurable pain assessments or goals listed on this plan of care to measure the outcomes of the interventions.</p> <p>On 5/30/14 at 2:26 PM, Employee C indicated the medication list on the plan of care failed to include the dose, frequency, and route of administration for the medication: Fentanyl and that no measurable goals were listed to assess the patient's pain levels and understanding of the teaching with pain control that was to occur.</p> <p>4. Clinical record #14 with a diagnosis of wound disruption evidenced two starts of care. One occurred on 8/12/13 and the other on 2/26/14. The record evidenced a plan of care for the certification period of 12/10/13 - 2/7/14 which was not signed by the physician until 1/16/14. There was no other plan of care after this certification period. There were no orders for skilled nurse visits which were documented on 2/18/14 and 3/7/14. An oasis start of care assessment completed by the RN on 2/26/14.</p>	{N 524}			

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{N 524}	<p>Continued From page 53</p> <p>On 5/30/14 at 9:45 AM, Employee C indicated there was no plan of care for the skilled nurse visits that occurred on 2/18/14 and 3/7/14 and the oasis start of care assessment completed by the RN on 2/26/14.</p> <p>5. Clinical record #15, SOC 8/23/13 and a diagnosis of diabetes mellitus, included plans of care for the certification periods of 12-21-13 - 2-18-14 (HHA to visit 1 - 2 times a week and skilled nurse 1 - 2 times a week), 2/19/14 - 4/19/14 (HHA 2 times a week and SN 1 times a week) and 4/20/14 - 6/18/14 (SN one times a week). The plan of care for 2/19/14 - 4/19/14 was not signed until 5/19/14 by the physician.</p> <p>A clinical document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance since 12/13." This included the signature of Employee A, administrator.</p> <p>6. Clinical record #16, start of care 10/23/13 and diagnosis of bronchitis, included a plan of care for the certification period of 4/21/14 - 6/19/14. This plan of care was not signed by the physician.</p> <p>On 6/2/14 at 11:06 AM, Employee A, administrator, indicated the plan of care was not signed.</p> <p>7. Clinical record #17, start of care 10/2/12 with a certification period of 4/3/14 - 6/1/14 failed to evidence the frequency and duration of skilled nurse visits which occurred on 4/3/14, 4/9/14, 4/16/14, 4/23/14, and 4/24/14. This plan of care was not signed by the physician.</p>	{N 524}		

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{N 524}	<p>Continued From page 54</p> <p>a. On 5/30/14 at 1:15 PM, Employee C indicated the plan of care was not signed.</p> <p>b. On 6/3/14 at 1:30 PM, Employee A indicated the frequency and duration of skilled nurse visits was not included on the plan of care.</p> <p>8. Clinical record #19, SOC 4/17/14 and diagnosis of obstructive chronic bronchitis, included a plan of care for the certification period of 4/17/14 - 6/15/14. This plan of care was not signed until 5/27/14 by the physician.</p> <p>On 6/3/14 at 2:15 PM, Employee A indicated the plan of care was not signed in a timely manner.</p> <p>9. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. the plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... An individualized plan of car signed by the physician shall be required for each patient receiving home health and personal care services. The plan of care shall be completed in full to include ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for</p>	{N 524}		

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{N 524}	Continued From page 55 changes in the plan of care."	{N 524}		
{N 527}	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the agency staff promptly alerted the physician to any changes that suggested a need to alter the plan of care for 1 of 12 records reviewed (#17) with the potential to affect all of the agency's active patients. Findings 1. On 5/30/14 at 4 PM, Employee I, Registered Nurse, indicated patient #17 had fallen on 4/24/14 and then cut self on arms on 4/29/14 with a knife. Employee E, the home health aide, called with an update. The nurse did not write any notes on this incident and did not write a transfer oasis. An informal caregiver took the patient to the emergency room where the patient was admitted and stayed several days. 2. Clinical record #17, start of care 10/2/12, failed to evidence the physician had been notified regarding of the fall and self cutting.	{N 527}		
N 529	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report	N 529		

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N 529	<p>Continued From page 56</p> <p>for each patient shall be sent to the:</p> <p>(A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months.</p> <p>This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure written summary reports were completed and sent to the physician at least every 60 days in 1 of 10 records (#16) reviewed of patients receiving services over 60 days creating the potential to affect all the agency's patients receiving services over 60 days.</p> <p>Findings</p> <p>1. Clinical record #16, start of care 10/23/13 and a diagnosis of bronchitis, failed to evidence a 60 day summary had been completed and sent to the physician for the certification period ending 4/20/14.</p> <p>2. On 6/2/14 at 11:05 AM, the administrator indicated the summary had not been completed.</p>	N 529			
{N 537}	<p>410 IAC 17-14-1(a) Scope of Services</p> <p>Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure skilled</p>	{N 537}			

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{N 537}	<p>Continued From page 57</p> <p>nursing services had been provided in accordance with physician's orders in 5 of 12 records reviewed (#7, 12, 13, 14, 16) creating the potential to affect all of the agency's patients that receive skilled nursing services.</p> <p>Findings</p> <p>1. Clinical record #7, start of care (SOC) 7/26/13 with a diagnosis of Congestive Heart Failure, included a plan of care for the certification period of 3/23/14 - 5/21/14. A nurse visit on 4/11/14 at 9 AM failed to show that the nurse had completed orders on the plan of care including assessing for edema and peripheral circulation. The nurse failed to complete a body system assessment that was ordered. The nurse failed to complete a pain assessment.</p> <p>On 5/20/14 at 2:55 PM, Employee C, Registered Nurse (RN) indicated the visits above did not follow the plan of care.</p> <p>2. Clinical record #12, SOC 10/23/13 with a diagnosis of benign hypertension, evidenced no plan of care for the certification period of 4/21/14 - 6/19/14 on 5/29/14 at 10:15 AM. On 6/2/14 at 10 AM, the clinical record did contain a plan of care for the certification period of 4/21/14 - 6/19/14. This plan of care evidenced the skilled nurse was to visit the patient 1 times a week for 9 weeks to assess pain level, instruction on shortness of breath, weekly weights, assess and instruct on pain management, proper body mechanics and safety measures, to instruct on proper foot wear when ambulating, and to encourage the patient to see a podiatrist. No skilled nurse visits were completed in the clinical record.</p>	{N 537}		

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{N 537}	<p>Continued From page 58</p> <p>a. On 5/29/14 at 10:15 AM, Employee C indicated the plan of care had not been completed and was not part of the clinical record and that skilled nurse visits were not in the record.</p> <p>b. On 5/29/14 at 2:00 PM, Employee I, RN, was observed to have a blank piece of papers with visit notes for the past two months noted on this paper. She indicated that she did not document the visit until later at home. This paper was divided into about 8 sections and vital signs and the date were recorded. The paper did not indicate what part of the plan of care had been completed besides vital signs. There was no pain assessments or instructions for proper foot wear noted.</p> <p>c. On 6/3/14 at 2 PM, Employee A indicated that the skilled nurse visits were missing from the record and documentation of a visit should be on a visit note or in the software program for skilled nurse visits used by the agency. Employee A indicated Employee I had not been documenting her skilled nurse visits timely or according to policy.</p> <p>3. Clinical record #13, SOC 3/29/14, evidenced a plan of care for the certification period of 3/29/14 - 5/27/14 that was electronically signed by Employee I on 3/25/14. The physician signed this plan of care on 5/10/14. Skilled nurse visits were made on 4/15/14, 4/22/14, 4/29/14, 5/9/14, 5/17/14, 5/20/14, and 5/27/14. There was no frequency of skilled nurse visits on this plan of care.</p> <p>On 5/30/14 at 2:25 PM, Employee C indicated the skilled nurse had not followed the plan of care.</p>	{N 537}			

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{N 537}	<p>Continued From page 59</p> <p>4. Clinical record #14 with a diagnosis of wound disruption evidenced two starts of care. One occurred on 8/12/13 and the other on 2/26/14. The record evidenced a plan of care for the certification period of 12/10/13 - 2/7/14, which was signed on 1/16/14. There was no other plan of care after this certification period. There were no orders for Skilled nurse visits which were documented on 2/18/14 and 3/7/14. An oasis start of care assessment completed by the RN on 2/26/14.</p> <p>On 5/30/14 at 9:45 AM, Employee C indicated that there was no plan of care for the skilled nurse visits that occurred on 2/18/14 and 3/7/14 and the oasis start of care assessment completed by the RN on 2/26/14.</p> <p>5. Clinical record #16, start of care 10/23/13 and diagnosis of bronchitis, evidenced the skilled nurse used triple antibiotic ointment on the patient's skin tear on without obtaining an order on 5/13/14 at 11:35 AM. It was not documented where the skin tear was.</p> <p>On 6/2/14 at 11:20 AM, Employee A, the administrator, indicated there was no order for this treatment.</p> <p>6. The agency policy titled "Scope of Practice" with no effective date stated, "Agency will provide services that are in compliance with acceptable professional standards for the Home Care Industry as well as the state and federal laws and identified agency performance improvement standards ... patient care will be provided under the plan of care established by a physician ... agency staff will deliver services based on each patient's unique and individual needs."</p>	{N 537}		

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{N 537}	Continued From page 60 7. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. the plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... An individualized plan of care signed by the physician shall be required for each patient receiving home health and personal care services. The plan of care shall be completed in full to include ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for changes in the plan of care." 8. The agency policy titled "Skilled Nursing Services" with no effective date stated, "Skilled nursing services will be provided by a Registered Nurse or a Licensed Practical / Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care [Physician's Orders]. In determining whether a service requires the skills of a Nurse, the inherent complexity of the service, condition of the patient, and accepted standards of medical and nursing practice will be considered ... The registered nurse a. Performs the initial assessment visit, b. Regularly reevaluates the patient needs, and coordinates necessary	{N 537}		

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{N 537}	Continued From page 61 services c. Initiates the plan of care and necessary revisions and updates to the plan of care and the care plan d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures e. informs the physician and other personnel of changes in the patient condition and needs ... prepares clinical and progress notes."	{N 537}		
N 541	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. This RULE is not met as evidenced by: Based on clinical record and document review and interview, the agency failed to ensure the registered nurse reevaluated the patient's needs when the patient returned home from a hospital admission in 1 of 12 records reviewed creating the potential to affect all the patients who were hospitalized (patient #14). The findings include 1. Clinical record #14, start of care 8/12/13, failed to evidence a comprehensive assessment had been completed within 48 hours of the patient's discharge from the hospital for treatment of a failing permacath. 2. A document titled "Community Healthcare System" and dated 2/21/14 evidenced the patient had been hospitalized from 2/21/14 - 2/23/14 for	N 541		

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NAME OF PROVIDER OR SUPPLIER INCARE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		
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N 541	Continued From page 62 a failing permacath. 3. On 5/30/14 at 2:26 PM, Employee C indicated the patient had been discharged from the hospital on 2/23/14 and had not been reevaluated when he/she returned home.	N 541			
N 545	410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. This RULE is not met as evidenced by: Based on clinical record review, interview, and policy review, the agency failed to ensure all personnel furnishing services documented the coordination of care while services were being provided for 7 of 12 records reviewed (12, 14, 15, 16, 17, 21, and 22) with the potential to affect all agency patients receiving more than one service. Findings: 1. On 5/28/14 at 11:50 AM, Employee C, the alternate director of nursing, indicated not sharing any patients with other agencies. 2. Clinical record #12, start of care (SOC) 10/23/13 with a diagnosis of benign hypertension, included a plan of care for the certification period of 4/21/14 - 6/19/14 and services of home health aide services, skilled nurse, and podiatrist. The clinical record failed to show coordination of care between the skilled nurse, the home health aide, or the podiatrist.	N 545			

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N 545	<p>Continued From page 63</p> <p>On 5/29/14 at 10:15 AM, Employee C indicated no coordination of care had occurred.</p> <p>3. Clinical record #14, SOC 8/12/13 with a diagnosis of wound disruption, evidenced the patient was receiving dialysis services along with skilled nurse services. The clinical record failed to evidence coordination of care with the dialysis facility and the skilled nurse.</p> <p>a. On 5/28/14 at 7 PM, patient #14 indicated being on home hemodialysis at SOC and completing this dialysis at home three times a week until switching to nocturnal hemodialysis in a nearby dialysis facility in December 2013. Patient #14 indicated telling the skilled nurse about this care received from a dialysis facility.</p> <p>b. On 5/30/14 at 9:45 AM, Employee C indicated there was no coordination of care noted in the record between the skilled nurse and dialysis facility.</p> <p>4. Clinical record #15, SOC 8/23/13 and a diagnosis of diabetes mellitus, included plans of care for the certification periods of 2/19/14 - 4/19/14 and 4/20/14 - 6/18/14. The plan of care for 2/19/14 - 4/19/14 was signed on 5/19/14 by the physician. The services ordered were home health aide and skilled nurse services. This record evidenced the home health aide was to visit two times a week for 9 weeks for these certification periods. The home health aide had been visiting the patient but had not turned in documentation since December 2013. The administrator was aware but the concern was not corrected or documented. The record failed to evidence coordination between the skilled nurse and home health aide.</p>	N 545			

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N 545	<p>Continued From page 64</p> <p>a. On 5/29/14 at 12:05 PM, Employee A was called by phone with Employee C and Employee R present. Employee A indicated Employee C was sent to patient #15's home to check if Employee S, HHA, was still caring for this patient under the agency's care. Employee A indicated that Employee S had terminated earlier this year, but did not give a date of termination. Employee A stated, "Why she never reported this, I don't know. There is a physician order, but she maintains contact with the patient. This is under investigation with our consultant." Employee A indicated that Employee I, RN, is responsible for this. Employee A indicated that Employee I had made progress in her work with the agency but still needed to make improvement with documentation with her care of the patients. Employee A indicated that Employee I does supervise the home health aides well and was in charge of supervision of this aide. The patient was pleased with this care from the agency.</p> <p>b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15.</p> <p>c. On 5/29/14 at 4:50 PM, Employee C indicated visiting patient #15 over the past weekend. Patient #15 was happy with the services from Incare and the aide. Employee C indicated she was sent in by Employee A to check on the services of Employee S, HHA. Employee C indicated not knowing that the Employee S had resigned. She only knew that no documentation had been sent in for months from the Employee S HHA's visits and she was to investigate if Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S</p>	N 545		

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N 545	<p>Continued From page 65</p> <p>was providing HHA services.</p> <p>d. On 5/30/14 at 11:55 AM, Employee S was called via telephone and spoke to writer and Employee C. She indicated still working for the agency and caring for patient #15. She indicated not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient she saw for the agency. She indicated she was sorry she had not turned in the notes and asked if she was in trouble.</p> <p>e. A document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance since 12/13." This included the signature of Employee A, administrator.</p> <p>F. Three documents were evidenced to be home health aide care plans and were dated on 12/18/13, 2/18/14, and 4/18/14.</p> <p>5. Clinical record #16, SOC 10/23/13 and diagnosis of bronchitis, failed to evidence coordination of care with an agency which provided homemaker services. Also an order for a social work evaluation on 4/21/14 evidenced the patient had refused. However, the order and refusal did not discuss any details about how the order was refused and if the social worker or physician were aware of the refusal. The record failed to evidence coordination of care with the other agency.</p> <p>a. On 6/2/14 at 10:30 AM, Employee CC, licensed practical nurse, indicated the patient was also seen by a home health agency that provided</p>	N 545		

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N 545	<p>Continued From page 66</p> <p>homemaker services.</p> <p>b. On 6/2/14 at 11:05 AM, the administrator indicated the patient had refused social work services and there was no other documentation about this refusal.</p> <p>6. Clinical record #17, start of care 10/2/12 with a certification period of 4/3/14 - 6/1/14, included an order on the plan of care that stated, "Physician's order, 4/2/14, MSW [Master's of Social Work] eval [evaluation]" This was dated 4/2/14 and signed by Employee A, administrator and director of nursing, and not signed by the physician. The patient had a primary diagnosis of benign hypertension. The record failed to evidence coordination of care between the social worker or the nurse.</p> <p>a. On 5/30/14 at 4:45 PM, Employee C, the alternate administrator indicated the social work evaluation was not in the record and that no care coordination had occurred with the social worker or the nurse.</p> <p>b. On 6/3/14 at 1:30 PM, Employee A indicated the patient had refused to see a social worker. There was no order or other communication to the doctor or agency nurse about this care refusal and need for the patient to see the social worker.</p> <p>7. Clinical record #21, SOC 10/4/13 and discharge on 3/25/14 and diagnosis of brain neoplasm, included a plan of care for the certification period of 2/1/14 - 4/1/14. The payment source was listed as Medicare. This plan of care indicated the patient was to receive skilled nurse visits 1 - 2 X weekly for 9 weeks and HHA visits for personal care including showers 1 -</p>	N 545			

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N 545	<p>Continued From page 67</p> <p>2 times a week for 9 weeks. There were also HHA visits documented for 3/25/14, 4/3/14, 4/9/14, 4/11/14, 4/16/14, 4/18/14, 4/22/14, and 4/24/14 after the discharge of this patient. There was an aide care plan dated on 1/30/14 that had no tasks for the home health aide to complete.</p> <p>On 6/3/14 at 7:45 AM, patient #21 indicated not knowing he / she was receiving services from the home health agency. Patient #21 indicated not being aware of being discharged. There was no care communication that showed the patient had been discharged in the record.</p> <p>8. Clinical record #22, SOC 10/1/13 and a diagnosis of paraplegia, included a plan of care for the certification period of 3/30/14 - 5/28/14 and payment source as Medicare. Included in the record were HHA visits from record #21 with the name of patient #21 documented. Ordered on this plan of care was the skilled nurse frequency of 1 time week for 9 weeks and HHA 2 times a week for 9 weeks. HHA visits occurred on 4/2/14, 4/4/14, 4/8/14, 4/10/14, 4/15/14, 4/17/14, 4/23/14, 4/25/14, 4/29/14, 4/30/14, 5/1/14, 5/7/14, 5/9/14, 5/13/14, and 5/15/14. SN visits occurred on 3/25/14, 4/10/14, 4/23/14, 4/30/14, 5/7/14, 5/14/14, and 5/21/14. HHA visits documented as to patient #21 were also in this record. These were from the following dates: 4/9/14, 4/11/14, 4/16/14, 4/18/14, 4/22/14, 4/24/14, 4/30/14, 5/2/14.</p> <p>a. On 6/3/14 at 10:25 AM, Employee W, registered nurse, indicated that patient #22 was the only one of patients #21 and #22 receiving home health aide services. Patient #21's visits were used for patient #22. Employee W indicated he was the primary nurse visiting patient #22 and conducting aide supervision. There was no</p>	N 545		

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N 545	Continued From page 68 documentation of care communication in the record between the services. b. On 6/3/14 at 1:05 PM, the administrator indicated that she was looking into this situation with patients #21 and #22. She stated, "We are not benefiting from this. [The patient] has private pay." 9. The agency policy titled "Coordination of Patient services" with no effective date stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current Care plans and written and verbal interaction ... Interdisciplinary care conferences shall be conducted as often as necessary to respond to changes in the patient's needs, services, care, or goals ... Ongoing care conferences shall be conducted to evaluate the patient's status and progress." 10. The agency policy titled "Skilled Nursing Services" with no effective date stated, "The registered nurse a. Performs the initial assessment visit, b. Regularly reevaluates the patient needs, and coordinates necessary services."	N 545			
{N 546}	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's	{N 546}			

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{N 546}	Continued From page 69 condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the agency staff promptly alerted the physician to any changes that suggested a need to alter the plan of care for 1 of 12 records reviewed (#17) with the potential to affect all of the agency's active patients. Findings 1. On 5/30/14 at 4 PM, Employee I, Registered Nurse, indicated patient #17 had fallen on 4/24/14 and then cut self on arms on 4/29/14 with a knife. Employee E, the home health aide, called with an update. The nurse did not write any notes on this incident and did not write a transfer oasis. An informal caregiver took the patient to the emergency room where the patient was admitted and stayed several days. 2. Clinical record #17, start of care 10/2/12, failed to evidence the physician had been notified regarding of the fall and self cutting.	{N 546}		
N 596	410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency	N 596		

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N 596	Continued From page 70 evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and This RULE is not met as evidenced by: Based on personnel file and policy review and interview, the agency failed to ensure the home health aide had completed a competency evaluation prior to furnishing services in 1 of 2 home health aide files reviewed (U) with the potential to affect all the patients that receive aide services from employee U. Findings 1. Employee U, Home Health Aide, date of hire 4/9/09 and first patient contact in 2009, failed to include a competency skills evaluation had been completed upon hire. 2. The agency policy titled "Home Health Aide services" with no effective date stated, "Only home health aides who meet required standards will provide direct care." 3. On 5/29/14 at 12:21 PM, Employee C, RN, indicated the personnel records were not complete.	N 596		
{N 606}	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.	{N 606}		

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{N 606}	<p>Continued From page 71</p> <p>This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the registered nurse had made a supervisory visit to the patient's home at least every 30 days in 2 of 9 records reviewed of patients (#12 and #15) that received home health aide and skilled services creating the potential to affect all of the agency's patients that receive skilled and home health aide services.</p> <p>Findings</p> <p>1. Clinical record #12 evidenced home health aide (HHA) services had been ordered 1- 2 times a week for 9 weeks during the certification period of 4/21/14 - 6/29/14 and skilled nurse had been provided 1 - 2 times a week for 9 weeks. The record evidenced that no supervisory visits had been provided from 4/21/14 - 5/29/14 by the registered nurse.</p> <p>On 5/29/14 at 10:15 AM, Employee C, Registered Nurse, indicated the supervisory notes were missing from the record.</p> <p>2. Clinical record #15, Start Of Care 8/23/13 and a diagnosis of diabetes mellitus, included plans of care for the certification periods of 12-21-13 - 2-18-14 (HHA to visit 1 - 2 times a week and skilled nurse 1 - 2 times a week), 2/19/14 - 4/19/14 (HHA 2 times a week and SN 1 times a week, and 4/20/14 - 6/18/14 (SN one times a week). The plan of care for 2/19/14 - 4/19/14 was signed on 5/19/14 by the physician. The home health aide had been visiting the patient but had not turned in documentation since December 2013. The administrator was aware but the concern was not corrected or documented. Home health aide visits had been made since December 2013 with no documentation in the</p>	{N 606}		

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{N 606}	<p>Continued From page 72</p> <p>record. The registered nurse had not supervised these visits during this time.</p> <p>a. On 5/29/14 at 12:05 PM, Employee A, administrator, was called by phone with Employee C and Employee R present. Employee A indicated that Employee C was sent to patient #15's home to check if Employee S, HHA, was still caring for this patient under the agency's care. Employee A indicated that Employee S had terminated earlier this year, but did not give a date of termination. Employee A stated, "Why she never reported this, I don't know. There is a physician order, but she maintains contact with the patient. This is under investigation with our consultant." Employee A indicated that Employee I, Registered Nurse, is responsible for this. Employee A indicated that Employee I has made progress in her work with the agency but still needs to make improvement with documentation with her care of the patients. Employee A indicated that Employee I does supervise the home health aides well and was in charge of supervision of this aide. However, the employee had not looked at any documentation of the aide's visits. The patient was pleased with this care from our agency.</p> <p>b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15.</p> <p>c. On 5/29/14 at 4:50 PM, Employee C indicated visiting patient #15 over the past weekend. Patient #15 was happy with the services from Incare and the aide. Employee C indicated that she was sent in by Employee A to check on the services of an Employee S, HHA. Employee C indicated not knowing that Employee</p>	{N 606}			

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{N 606}	Continued From page 73 S had resigned. She only knew that no documentation had been sent in for months from Employee S HHA's visits and she was to investigate if Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services. d. On 5/30/14 at 11:55 AM, Employee S called via telephone and spoke to writer and Employee C. She indicated still working for the agency and caring for patient #15. She indicated not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient she saw for the agency. She indicated she was sorry she had not turned in the notes and asked if she was in trouble. e. A clinical document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance since 12/13 " This included the signature of Employee A, administrator.	{N 606}		
{N 608}	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed	{N 608}		

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NAME OF PROVIDER OR SUPPLIER INCARE HOME HEALTHCARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 608}	<p>Continued From page 74</p> <p>to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.</p> <p>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</p> <p>(6) A discharge summary.</p> <p>This RULE is not met as evidenced by: Based on clinical record review, agency document and policy review, other document review, and interview, the administrator failed to ensure 7 of 12 clinical records (clinical record #14 - #18, #21, #22) reviewed were accurate and maintained according to policy creating the potential to affect all of the agency's 72 current patients.</p> <p>The findings include:</p> <p>Regarding clinical record #14</p> <p>1. Clinical record #14 evidenced skilled nursing services had been provided 1 - 2 times a week for 9 weeks during the certification period of 12/10/13 - 2/7/14 and also were provided on 2/18/14 and 3/7/14. The patient had been transferred to the hospital on 2/2/14 and returned home on 2/23/14. Neither a transfer or discharge had occurred to show that the patient had been discharged and then no resumption of care had occurred when the patient returned home. However, an oasis start of care assessment was completed by the RN on 2/26/14. The record was kept as a closed record in a file cabinet for closed records, but failed to show that any discharge assessment or summary had occurred or that a resumption of care occurred. It was not known that the patient had been discharged.</p>	{N 608}		

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{N 608}	<p>Continued From page 75</p> <p>a. A document titled "Community Healthcare System and dated 2/21/14 evidenced the patient had been hospitalized from 2/21/14 - 2/23/14 for a failing permacath.</p> <p>b. On 5/28/14 at 7 PM, patient #14 indicated that services stopped and that he / she had not been notified of this change in the plan of care.</p> <p>c. On 5/30/14 at 9:10 AM, Employee C indicated no hospital transfer or discharge oasis had been completed at patient #14's end of care. This was not following policy. Employee C indicated the patient had signed the patient rights and had signed consent for a new start of care on 2/26/14 and had been visited by the skilled nurse. There were no orders and no plan of care for this care provided.</p> <p>d. On 5/30/14 at 2:26 PM, Employee C indicated that the patient had been discharged from the services of the agency and there was no discharge OASIS assessment or discharge summary. The patient had been transferred to the hospital on 2/21/13 and returned home on 2/23/14. There was no resumption of care.</p> <p>Regarding clinical record #15</p> <p>2. Clinical record #15, start of care (SOC) 8/23/13 and a diagnosis of diabetes mellitus, included plans of care for the certification periods of 2/19/14 - 4/19/14 and 4/20/14 - 6/18/14. The plan of care for 2/19/14 - 4/19/14 was signed on 5/19/14 by the physician. This record evidenced the home health aide was to visit two times a week for 9 weeks for these certification periods. The home health aide had been visiting the patient but had not turned in documentation since</p>	{N 608}		

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{N 608}	<p>Continued From page 76</p> <p>December 2013. The administrator was aware but the concern was not corrected or documented.</p> <p>a. On 5/29/14 at 12:05 PM, Employee A was called by phone with Employee C and Employee R present. Employee A indicated that Employee C was sent to patient #15's home to check if Employee S, home health aide (HHA), was still caring for this patient under the agency care. Employee A indicated that Employee S had terminated earlier this year, but did not give a date of termination. Employee A stated, "Why she never reported this, I don't know. There is a physician order, but she maintains contact with the patient. This is under investigation with our consultant." Employee A indicated that Employee I, registered nurse (RN), is responsible for this. Employee A indicated that Employee I has made progress in her work with the agency but still needs to make improvement with documentation with her care of the patients. Employee A indicated that Employee I does supervise the home health aides well and was in charge of supervision of this aide. The patient is pleased with this care from the agency.</p> <p>b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15.</p> <p>c. On 5/29/14 at 4:50 PM, Employee C indicated visiting patient #15 over the past weekend. Patient #15 was happy with the services from Incare and the aide. Employee C indicated that she was sent in by Employee A to check on the services of an Employee S, HHA. Employee C indicated not knowing that Employee S had resigned. She only knew that no</p>	{N 608}			

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{N 608}	<p>Continued From page 77</p> <p>documentation had been sent in for months from Employee S HHA's visits and she was to investigate if Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services.</p> <p>d. On 5/30/14 at 11:55 AM, Employee S called via telephone and spoke to writer and Employee C. She indicated still working for the agency and caring for patient #15. She indicated not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient she saw for the agency. She indicated she was sorry she had not turned in the notes and asked if she was in trouble.</p> <p>e. A clinical document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance since 12/13." This included the signature of Employee A, administrator.</p> <p>f. Three clinical documents were evidenced to be home health aide care plans and were dated on 12/18/13, 2/18/14, and 4/18/14.</p> <p>Regarding clinical record #16</p> <p>3. Clinical record #16, SOC 10/23/13 and a diagnosis of bronchitis, included a plan of care for the certification period of 4/21/14 - 6/19/14 evidenced an active record. However, the patient had been transferred on 5/16/14 and then discharged. The patient was listed on the active patients list on 5/28/14. However, the clinical</p>	{N 608}			

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{N 608}	<p>Continued From page 78</p> <p>record was closed.</p> <p>a. A document titled "Incare Home Healthcare, inc. Patient Survey Census" with an effective date of 5/28/14 included patient #16's name, medicare #, date of birth, SOC date as 10/23/13 and certification period of 4/21/14 - 6/19/14, diagnosis of bronchitis, and disciplines of skilled nursing and home health aide.</p> <p>b. On 6/2/14 at 10:25 AM, Employee A indicated the discharge was pending in the computer software program called AXCESS, since she was still learning features of the program.</p> <p>Regarding clinical record #17</p> <p>4. A document titled "Incare Home Healthcare, inc. Patient Survey Census" with an effective date of 5/28/14 included patient #17's name, medicare #, date of birth, SOC date as 2/2/14 and certification period of 4/3/14 - 6/1/14, diagnosis of benign hypertension, and disciplines of skilled nursing and home health aide.</p> <p>a. On 5/29/14 at 12:15 PM, Employee C, the alternate administrator, was unable to find patient #17's record.</p> <p>b. On 5/30/14 at 11:40 AM and at 1:10 PM, Employee C was unable to find patient #17's record.</p> <p>c. On 5/30/14 at 4 PM, the owner of the agency, Employee R, found the clinical record in the discharged records. The patient's last home health aide visit had occurred on 4/29/14 and the patient had been transferred to the hospital on</p>	{N 608}		

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{N 608}	<p>Continued From page 79</p> <p>that date. There was no transfer or discharge oasis documentation evidenced in the clinical record.</p> <p>d. On 5/30/14 at 4:30 PM, Employee I, Registered Nurse, indicated the patient had been transferred to the hospital on 4/29/14 and was now discharged. No transfer oasis or discharge assessment or summary had been completed.</p> <p>e. On 6/3/14 at 1:35 PM, Employee A, the administrator, indicated the patient was discharged and not active as patient records indicated.</p> <p>Regarding Clinical record #18</p> <p>5. On 5/28/14 at 3:45 PM, Employee C indicated that patient #18's record was not able to be found.</p> <p>a. On 6/2/14 at 12:20 PM, Patient #18's record was located with a discharge summary and assessment.</p> <p>b. On 6/2/14 at 12:20 PM, the administrator indicated patient #18's record was complete.</p> <p>Regarding Clinical records #21 and #22</p> <p>6. Clinical record #21, SOC 10/4/13 and discharge on 3/25/14 and diagnosis of brain neoplasm, included a plan of care for the certification period of 2/1/14 - 4/1/14. The payment source was listed as Medicare. This plan of care indicated the patient was to receive skilled nurse (SN) visits 1 - 2 times weekly for 9 weeks and HHA visits for personal care including</p>	{N 608}			

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{N 608}	<p>Continued From page 80</p> <p>showers 1 - 2 times a week for 9 weeks. (Interviews with staff and the informal caregiver and the patient indicated that the patient received no personal care from the HHAs through this time.) There were also HHA visits documented for 3/25/14, 4/3/14, 4/9/14, 4/11/14, 4/16/14, 4/18/14, 4/22/14, and 4/24/14 after the discharge of this patient. There was an aide care plan dated on 1/30/14 that had no tasks for the home health aide to complete.</p> <p>7. Clinical record #22, SOC 10/1/13 and a diagnosis of paraplegia, included a plan of care for the certification period of 3/30/14 - 5/28/14 and payment source as Medicare. Included in the record were HHA visits from record #21 with the name of patient #21 documented. Ordered on this plan of care were the SN frequency of 1 time per week for 9 weeks and HHA 2 times a week for 9 weeks. HHA visits occurred on 4/2/14, 4/4/14, 4/8/14, 4/10/14, 4/15/14, 4/17/14, 4/23/14, 4/25/14, 4/29/14, 4/30/14, 5/1/14, 5/7/14, 5/9/14, 5/13/14, and 5/15/14. SN visits occurred on 3/25/14, 4/10/14, 4/23/14, 4/30/14, 5/7/14, 5/14/14, and 5/21/14. HHA visits documented as to patient #21 were also in this record. These were from the following dates: 4/9/14, 4/11/14, 4/16/14, 4/18/14, 4/22/14, 4/24/14, 4/30/14, and 5/2/14.</p> <p>On 6/3/14 at 1:05 PM, the administrator indicated that she was looking into this situation with patients #21 and #22. She stated, "We are not benefiting from this. [The patient] has private pay."</p> <p>8. The agency policy titled "Clinical documentation" with no effective date stated, "Agency will document each direct contact with the patient. This documentation will be</p>	{N 608}		

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{N 608}	Continued From page 81 completed by the direct caregivers and monitored by the skilled professional responsible for managing the patient's care ... to ensure that there is an accurate record of the services provided, patient response and ongoing need for care ... to document conformance with the plan of care, modifications to the plan, and interdisciplinary involvement ... documentation of the services ordered on the plan of care will be completed the day service is rendered and incorporated into the clinical record within 7 days after the care has been provided." 9. The agency policy titled "Clinical records / Medical Record Retention" and no effective date stated, " Clinical record [is] A confidential clinical record containing pertinent past and current findings in accordance with professional standards is maintained for every patient receiving home health services."	{N 608}		